Global Leadership

Findings from the CEO/Innovators Roundtable: **Healthcare in high gear**

This special report from Russell Reynolds Associates is part of an ongoing series that examines the complex challenges facing the global healthcare industry. In this discussion, we examine the regulatory, payment reform and service delivery issues facing Health Services organizations today.

Our second installment— Embracing Change: New Growth Drivers and Leadership Requirements—*addresses innovation and leadership issues in global Pharmaceutical and Biotech organizations.*

"Our medical bills shouldn't be based on the number of tests ordered or days spent in the hospital—they should be based on the quality of care that our seniors receive."

President Obama, February 12, 2013
State of the Union Address

Earlier this year we gathered for our most recent CEO/Innovators Roundtable in Washington, D.C., organized by Russell Reynolds Associates, BDC Advisors, and Foley & Lardner LLP—and what a difference a few months made. When we came together for our previous Roundtable in June of 2012, the healthcare field was in an unusual state of suspended animation. The overwhelming consensus at our event was that the healthcare industry was in need of transformation and innovation—and in many areas, as we saw, that change was well under way. Nonetheless, at the time, the Supreme Court had yet to weigh in on the Affordable Care Act, and the nation's voters were months away from a presidential election that threatened to stop healthcare reform in its tracks. Consumers; managed care payers; physician groups; and other healthcare providers, hospital systems and integrated health plans all were caught in between forces. It was hard to pivot when the nation's largest healthcare payer—the U.S. government—was in such a state of flux.

Shortly after our June event, however, the Supreme Court affirmed the legality of the health reform law, and in November, voters returned President Obama to office for a second term. With those two events, healthcare reform was instantly resuscitated. It was as if the patient was helped off the hospital bed and ushered to the starting line of a marathon—and was expected to win. Meanwhile, all this was unfolding amidst talk of fiscal cliffs and impending budget sequestration.

President Obama let there be no doubt about the importance of transforming healthcare in the context of fiscal restraint when he declared in his inauguration speech that: "We must make

the hard choices to reduce the cost of healthcare and the size of our deficit." He drove home the point just two days after our Roundtable gathered in February, telling Scott Pelley of "CBS Evening News" during a Super Bowl interview: "We spend a lot more on healthcare than every other country does, and we don't get better outcomes—so there's a lot of waste in the system, and there are things that we can do to reduce healthcare costs." And if there was any doubt about the direction of change, Obama announced in his State of the Union address that: "We'll bring down costs by changing the way our government pays for Medicare. Our medical bills shouldn't be based on the number of tests ordered or days spent in the hospital—they should be based on the quality of care that our seniors receive." For those in the industry, the president's message was clear: The country's largest payer is moving away from fee-for-service to a broadly defined accountable care model.

Major Drivers of Change

- **Healthcare exchanges**
- **Technological advances**
- **Consumer demand**
- **Consumer behavior**
- **Private sector involvement**
- **Economics**

The first major step in this transformation is right around the corner. The Affordable Care Act-mandated health insurance exchanges are required by law to be operational next October, with plans ready to cover consumers by New Year's Day 2014. It will be a massive undertaking. As of the February 15, 2013, deadline for declaring their intentions, the majority of states (26 of them) essentially had punted on the issue, leaving it to the federal government to set up exchanges within their borders. Regardless of who is managing the exchanges, the net result will be an additional 20 million to 30 million Americans joining the health insurance risk pool. Employees who can't find suitable coverage at work will need to turn to the health insurance exchanges. It's projected that approximately 6 million people simply will opt out of private coverage and pay a tax penalty to remain uninsured.

The Affordable Care Act's exchanges are a powerful catalyst, but, as we've seen at our Roundtables, there are other equally strong forces at work that are spurring change, innovation and reform in healthcare. Consumers increasingly will be involved in the cost of their insurance and their own care, and their preferences will spark changes in the marketplace. Technology, including electronic medical records, diagnostic applications, consumer-empowering tools and Big Data analysis, also will stimulate industry transformation. Public companies able to raise vast amounts of capital on the open market, as well as private equity-backed companies, will compete for consumers alongside nonprofit hospital groups, traditional physician practices and health insurance organizations.

Economic, Consumer, Physician and Cost Challenges Are Enormous

While all these forces are pushing the healthcare field to reform, the hurdles can seem frustratingly high. On the surface, the healthcare economic news has been encouraging over the past few years, but it's still unsustainable. In 2012, healthcare expenditures grew by a mere 4.3 percent, capping four years of historically low growth. Yet the growth rate still is double that of the U.S. economy and continues to account for nearly18 percent of the U.S. gross domestic product. At this rate, healthcare expenses eventually will envelop the entire economy. At our Roundtable, one attendee pointed to a study in the *Annals of Family Medicine* that suggests that in just eight years, the cost of health insurance will consume 50 percent of a typical American family's income. The same study projected that by 2033, health insurance costs will exceed an average family's income. Merely slowing growth won't suffice as a viable reform solution. Cutting costs will be essential.

When it comes to physicians, anecdotal evidence indicates that younger doctors increasingly are embracing the models of integrated team-based care, capitated payment and population health management. However, it's also true that only 5 percent of physicians currently practice in an accountable care organization, and most of those who are not are highly dubious of the prospect of being involved. According to the 2012 Medscape survey of practicing physicians, nearly half (47 percent of the 25,000 physicians surveyed) felt that quality measures and treatment guidelines would have a negative impact on patient care, and 67 percent said they wouldn't reduce testing to contain costs. When it comes to cost transparency, the physician community is hardly an enabler. In fact, only 38 percent of physicians said they regularly discuss treatment costs with patients. Even when the patient initiates the conversation, the number rises to just 46 percent.

This suggests that consumer-driven cost transparency won't be particularly easy. On the bright side, new organizations are entering the healthcare space with the goal of helping employers and their employees understand and manage healthcare costs. For most consumers, however, the challenge is daunting. Consider the report from *JAMA Internal Medicine* that was released just a few days after we gathered in February. The report documented how incredibly difficult it is for consumers to obtain accurate pricing information, even on a widely practiced procedure such as hip replacement. Researchers called 100 randomly selected hospitals throughout the country plus 20 top orthopedic centers and asked for the bundled price (hospital and physician fees) of the hip replacement for a fictitious 62-year-old uninsured grandmother. Even after follow-up calls, just 12 of the top hospitals and 54 of the randomly selected hospitals could provide a cost projection, and those estimates ranged wildly from $11,100 to $125,798. In some cases, the estimates proved too high because hospitals were willing to negotiate lower rates, while with other hospitals, the price didn't factor in rehabilitation costs. This price inquiry was the work of an enlightened consumer—albeit a fictitious one—who knew which questions to ask and was comfortable with negotiations. The challenge for traditional consumers, who lack a basic understanding of the issues and who, historically, have been insulated from the true cost of healthcare, will be more dramatic.

Researchers called 120 hospitals to obtain the hip replacement cost for a fictitious 62-year-old uninsured grandmother.

Just over half the hospitals could deliver a quote.

Prices ranged from $11,100 to $125,798, and many quotes were erroneous.

***JAMA Internal Medicine* report**

While there is great hope in the power of consumers to drive change in healthcare, it's many of these same consumers who are responsible for the high healthcare costs. Take, for example, the issue of obesity in the United States. According to data from the Centers for Disease Control and Prevention, 35 percent of Americans are obese (with a body mass index greater than 30). The cost of treating obesity-related diseases was estimated at $190 billion per year by Cornell professor John Cawley in the *Journal of Health Economics*. If Cawley's numbers are right, that means obesity accounts for 21 percent of the nation's healthcare costs. Solve the obesity epidemic, and a major share of the healthcare cost problem disappears.

The trend line, however, is pointed in the other direction. A recent report by the Robert Wood Johnson Foundation projects that by 2030, the national obesity rate could climb to 44 percent, with several states in excess of 60 percent. Far from lowering the cost of healthcare, rising obesity rates will lead to increased healthcare costs. When it comes to smoking, approximately 20 percent of Americans still do so, accounting for another $96 billion in annual healthcare costs. It's worth repeating that solving for obesity and smoking virtually resolves the problem of taking 20 percent to 30 percent of costs out of the system. Yet, that's no easy task.

A report in the *New England Journal of Medicine* suggests that physicians adhere to published guidelines only 50 percent of the time.

The Solutions

Despite the vast challenges facing the healthcare industry, the talent and resources currently engaged in unraveling the long-term industry problems are equally enormous and impressive. At our CEO/Innovators Roundtables, we continue to be inspired by the ideas and actions of our attendees and their organizations. Since we began this twice-yearly event in 2009, we have heard from leaders and innovators in technology, science, public and private health insurance payer organizations, federal and state government executives, medical groups, hospitals, private equity and venture capital. These leaders have weighed in on the wide range of solutions and challenges in the healthcare field, from the promise of novel treatments to the management of data and consumer technology.

As we've heard from diverse groups throughout the country, the reality is that healthcare reform may look slightly different in various geographies. If there is one unifying consensus that has emerged since our last meeting, it's that some form of capitated payment/population-health management will be a central part of the solution. In order for that to occur, however, the economic incentives must be realigned so that physician groups, hospitals and other provider organizations are paid for keeping large populations of people healthy. In today's world, however, healthcare markets still operate in a volume-based fee-for-service environment.

Some transformative models that are having success include Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract and a restructuring program being studied at Kaiser Permanente. One model that drew some attention at our February event is that of the Southcentral Foundation, headquartered in Anchorage, Alaska. The nonprofit healthcare plan was honored last year with the U.S. Department of Commerce's Malcolm Baldrige Award for business innovation and performance. Southcentral operates 26 facilities serving 60,000 Alaska Natives (13,000 of whom live in remote wilderness areas accessible only by boat or plane). Patients are referred to as customer-owners, highlighting shared responsibility for their healthcare.

At Southcentral, care is delivered in a coordinated-care team process, generally consisting of a doctor, a nurse, two medical assistants, a behavioral health therapist and an administrative assistant. A team typically is responsible for approximately 1,400 patients and is connected to Southcentral pharmacists, nutritionists, and specialists such as eye doctors and dentists. Team members work in an open, collaborative environment with no offices or nursing stations and are compensated based on their performance, not on services ordered or performed.

In Alaska, the model is working well. Customer-owners can call the same day for an appointment as long as they do so by 4 p.m. and arrive by 4:30 p.m. Nurses field calls to determine if a customer-owner needs to come in or if the issue can be dealt with over the phone. Medical teams also rely on extensive outbound communication, using phone calls, emails and text messages to ensure that customer-owners are sticking to their health management plans. Each care team is hooked into a "data mall" of information, which, according to *The New York Times*, "coughs up easily understood graphics showing how well doctors and the teams they lead are doing to improve health outcomes and cut costs compared with their colleagues, their past performance and national benchmarks, and it provides them with action lists of what they can do

to improve and mentors to guide them." Doctors whose teams are underperforming their peers in, say, scheduling eye appointments for diabetics quickly catch up to the norm.

This same-day, always-on healthcare model has led to some astounding results:

- 50 percent decrease in emergency room and urgent care visits
- 53 percent decrease in hospital admissions
- 65 percent decrease in specialty care
- 35 percent decrease in primary care

Southcentral's system may not work everywhere, but it's an indication as to where healthcare is headed.

A report in the *New England Journal of Medicine* suggests that physicians only adhere to published guidelines 50 percent of the time.

Looking forward, on the first day of this winter's event, we asked our panelists to focus on how technology is transforming the industry and to offer insight on how provider groups and commercial aggregators/integrators are evolving in the midst of reform. The second day, we tackled the issue of consumer empowerment and the cost management imperative. If you were able to join us, we think you'll find this review a helpful way to keep the conversation and network building alive until our next meeting. If you weren't able to make it in February, we hope that this will help bring you up to speed on some of the ideas with which many industry innovators are experimenting and that you will be able to join us at the next CEO/Innovators Roundtable scheduled for October 10-11 in Chicago.

Finally, a brief note about these discussions and the writeups that follow: Each session during the event was moderated by experts in field—those listed at the top of each summary—but the discussions included lively debate, input and dialogue from the entire group of attendees.

Analytics Providers/"Intel Inside"

- Charles Saunders, M.D., Chief Executive Officer, Healthagen, a Division of Aetna
- John Doulis, M.B.B.S., Chief Information Officer, MedCare Investment Funds

What should the role of information technology be when it comes to transforming healthcare? Technology, of course, increasingly will be part of every facet of healthcare. It will assist in engaging patients in their health decisions, it will include the deployment of high-tech devices and it will encompass large-scale data analyses. On the macro level, one of the principal roles of technology will be to help providers flourish—to be successful in their jobs—under a population-health business paradigm. Healthcare organizations will be faced with three core issues as they seek to implement and accelerate the adoption of healthcare information technology solutions.

The first issue is gaining access to clinical and patient data. On a very basic level, it can be difficult to extrapolate data from patients' medical health records. The second issue is that health insurance claims data must then be integrated with clinical data. Situations where providers are forced to access multiple databases, often with a number of terminals sitting side by side, are untenable. While cataloging structured data such as universally accepted data fields is relatively easy, there is a wide range of unstructured data that can show up in patient records (images,

notes, videos, documents) that are difficult to integrate. Some highly integrated healthcare organizations have an advantage because they already capture both sets of data in an integrated format.

Assuming the data can be collected, aggregated and integrated digitally, the third and potentially most challenging issue is that meaning must be gleaned from these data. Can an analysis isolate the sickest patients in a given population? And can this analysis help determine what should be done to treat those patients? Only when these three issues are integrated will they begin to offer a real solution to healthcare organizations.

While those data problems are being addressed, there is an enormous challenge in disseminating the information to the provider community and ensuring that the solutions actually are leveraged. According to a report by the U.S. Agency for Healthcare Research and Quality, it takes 17 years for 50 percent of physicians to adopt published guidelines. Even when actionable data are available, the medical community doesn't always act on the information. Bending the cost curve will require a huge investment in technology, combined with strategies that promote broad-scale adoption by the medical community.

If there was a cautionary note about technology among the group, it was as a reminder not to become too enamored with it as a comprehensive solution but rather to view it as a catalyst for change. A consensus emerged that real healthcare solutions will come about when a care team—including the patient—is actively monitoring the data and responding to the information in real time.

Without patients playing a role and taking responsibility for their care, there is only so much that technology can do. This will prove to be a serious challenge to long-term success in the healthcare industry. Several studies have shown that patients typically adhere to their prescriptions only 45 percent to 55 percent of the time. One particular study found that within a month of a heart attack, only 70 percent of 17,000 patients were taking their prescribed beta-blockers—by the end of a year, the percentage had dropped to just 45 percent. Technology solutions such as automated phone calls, emails and texts will play a role in spurring patients into action, but, ultimately, the patient still must take the pill. Just as incentives are being realigned for physicians, they also need to be changed for consumers and patients.

Many organizations are using gamification, or game-focused platforms, to incentivize consumers to improve and manage their health. One healthcare entity uses rewards to ensure that pregnant women attend all their medical appointments. Other approaches may leverage consumers' online social networks as a way to get people to manage their fitness and health. Consumer products companies also are entering the consumer-engagement marketplace, which suggests that traditional players will be experiencing increased competition from outside the industry. Nike's FuelBand, which allows people to set daily fitness goals, track progress throughout the day and compete against friends, is just one example of modern technologies and emerging players in the healthcare technology field.

Complicating matters for traditional players are structural hurdles such as HIPPA, or Health Insurance Portability and Accountability Act, privacy rules. While the global trend is to share information widely, in healthcare, the law works in the opposite direction—clamping down on the

exchange of patient information. One solution discussed at the Roundtable may simply be to put a patient's health information on a microchip-enabled card. In this paradigm, patients would physically possess their electronic records and thus be able to control the use of the information by sharing it as broadly or as little as they choose.

What is clear is that unless patients and consumers are integrated and engaged in their own healthcare, the prospects for improving quality while decreasing costs are limited.

National Aggregators/Integrators Evolve—Providers

- Bernadette Loftus, M.D., Associate Executive Director, Mid-Atlantic Permanente Medical Group
- Brad Perkins, M.D., Executive Vice President for Strategy & Innovation and Chief Transformation Officer, Vanguard Health Systems

Most observers at the Roundtable posited that the healthcare system in the United States has 10 years to transform itself. A few attendees suggested change will take place much more quickly, spurred on by consumer expectations and technology. The future most likely will encompass a wide range of players, including academic medical centers, nonprofit healthcare systems, fully integrated healthcare organizations and for-profit health systems, as well as traditional payer organizations that are evolving into entirely new entities. In some markets, all these players will exist, while in other markets, one or another will dominate. Accountable care organizations in the western United States may look dramatically different from the way they do in Minnesota or, say, in the Mid-Atlantic or New England states.

The industry consolidation that nearly all believe is inevitable certainly will eliminate competitors in some markets, but it also will create new ones that seek to replicate and improve upon successful models. Organizations likely will be forced to compete for consumers in ways they never have before, providing quick, easy, affordable and quality healthcare in real time. One open question is where this inevitable consolidation will leave physicians. Will they increasingly become employees of large healthcare systems, sacrificing independence for stability and the ability to focus exclusively on medicine? Or will physicians partner with virtually integrated healthcare systems, maintaining independence while still leveraging the power of a larger organization? The answer to both of these questions, most likely, is yes.

When it comes to healthcare aggregators/integrators, both of these paradigms—fully integrated and virtually integrated—are emerging as viable models for the future. The nonprofit fully integrated program is one that employs its own physicians, nurses and other clinicians who practice in the organization's facilities, providing a one-stop shop for consumers. In this approach, the payer and provider are combined, enabling highly integrated data analysis and data solutions for physicians and consumers to leverage—with no need to gather and interpret information from a third party. One challenge for consumers is that these highly integrated health systems can limit consumers' perception of choice—such as being able to choose exactly which physician they want to see. To combat this perception, these closed-network plans must provide a high-quality, low-cost, finely tuned, patient-focused system that delivers on-demand access and care 365 days a year.

Competing on quality and cost, however, also is the metric by which for-profit virtually integrated models measure themselves. Indeed, these for-profit institutions have a discipline enforced upon them by quarterly earnings reports and investors who will flee if success isn't efficient and scalable. By rolling out effective solutions in a highly disciplined manner to its network of hospitals and care facilities, these virtually integrated systems may realize cost savings on the order of 30 percent to 40 percent. Instead of employing physicians directly, the virtually integrated model seeks to align them through a set of principles, guidelines and incentives. Underpinning this approach is an underlying belief that physicians and physician groups will leverage their independence to innovate when it comes to cost savings and healthcare solutions. If the program works, these organizations can go to the public equity markets in search of new capital that will enable them to scale quickly and efficiently.

Can both models survive—a nonprofit fully integrated process and a for-profit virtually integrated one—particularly in markets where they may compete head to head? The consensus in the group discussion was yes. Indeed, they likely will be competing against still other organizations that enter the accountable care environment. So what might accountable care organizations, broadly defined, look like in 10 years? One projection is that they will function as full-service health organizations, including pharmacies, home-health physicians and skilled nursing facilities adjacent to hospitals. If the scale is large enough, particularly in urban and suburban markets, it's possible that the accountable care organizations of tomorrow even may address the issue of food deserts, where, currently, access to high-quality, healthy food is severely limited. In this light, not only will healthcare organizations be treating chronic diseases such as obesity and its related ailments but getting at the root cause of them as well.

National Aggregators/Integrators Evolve—Commercial Players

- **Jeff Kang, M.D., M.P.H.**, Senior Vice President, Health and Wellness Services and Solutions, Walgreen Co.
- **Walter Ettinger, Jr., M.D.**, Executive Vice President and Chief Medical Officer, Accretive Health, Inc.
- **Paul Kusserow**, Senior Vice President, Chief Strategy, Innovations and Corporate Development Officer, Humana Inc.
- **Seth Frazier**, Senior Vice President, Chief Transformation Officer, Evolent Health

The provider universe is hardly the only area where innovation and disruption are taking place. Several commercial players are intent on gaining market share while improving healthcare outcomes and adopting integrated strategies that will accelerate the transition to accountable care business models. Retail pharmacies have long been part of the care delivery marketplace, and that trend looks to be accelerating. Not only do consumers receive medication at these retail outlets, but pharmacists, nurses and other licensed practitioners also administer vaccines, diagnose minor ailments and test for certain illnesses. In addition, these entities maintain databases that integrate consumer, payer and provider information. Such databases enable prescription reminders and other healthcare notices. Whereas provider groups tend to be housed in relatively few large hospitals and office complexes, retail pharmacies can be found at major

and minor intersections in nearly every city and town in the United States. These pharmacies operate throughout the income spectrum, providing a similar customer experience across demographic areas and payer groups, and, in most markets, they are open for business all day and most of the night, 365 days a year.

While provider groups initially may view these retail operations as competitive threats—taking fees away from physicians—there's a counter argument that pharmacies can play a complementary role in an accountable care model where access to primary care physicians is limited. In a population-health model, if pharmacies and their associated clinicians can handle an increasing share of non-emergency issues such as immunizations, blood pressure checks and chronic disease management, then primary care physicians can be freed to tackle more serious diagnostic issues with their patients. Both groups would share in the capitated revenue benefit.

Retail healthcare outlets are not the only players adapting their business to embrace an evolving healthcare model. Some payer organizations, for example, are offering services to their members that encourage them to live healthier lives. These patient decisions, in turn, will reduce costs. These tools can take the form of gamified reward programs that spur consumers to manage their health and, at the same time, enable the payer organizations to track members' success. Some entities are purchasing alternative care sites to deliver high-quality care outside of hospitals.

Indeed, hospitals may struggle the most in making the transition from fee-for-service to capitated payment. This is true not only because the vast majority of hospitals currently operate within a fee-for-service model but also because it's unclear how much it will cost to provide healthcare to an additional 30 million Americans who may be covered under the Affordable Care Act. So much of cost management in healthcare comes down to an actuarial management of the risk pools, and, today, the risk pool is in flux.

The Cost Management Imperative—Provider Responses

- **Richard Bankowitz, M.D.**, M.B.A., Fellow of the American College of Physicians, Chief Medical Officer, Premier
- **Gordon Norman, M.D.**, M.B.A., Chief Medical Officer, xG Health Solutions
- **Marc Hafer**, Chief Executive Officer, Simpler

Healthcare organizations have been grappling with cost cutting and sustainability for several decades, yet, today, the pressure is intense. The widely cited rule of thumb in the industry is that there's 30 percent waste in the system, but others in the group suggested the true amount could be closer to 80 percent. While those figures are troubling, solving for that waste also offers a path to sustainability for the industry.

So how will organizations across the healthcare spectrum reduce costs? Some entities will deploy technology; others will focus on the highest cost factors and tackle those issues. Healthcare systems have participated in purchasing alliances to leverage their buying power and bring down costs. Other organizations have had success by simply tackling medical issues,

positing that by delivering accurate, high-quality care, costs are being driven down. Hospital infections, for example, are responsible for $25 billion to $31.5 billion in unnecessary costs annually according to the Centers for Disease Control and Prevention. Other solutions include evidenced-based care management protocols, development of Patient Centered Medical Homes, and healthcare information technology integration and optimization.

One way or another, costs must come out of the system within the next decade. These changes either will come from inside the industry or through the blunt instrument of the nation's largest payer—the federal government—unilaterally reducing the amount it pays for medical services. In past sessions, we have discussed how changes instituted by the Centers for Medicare & Medicaid Services can have huge impacts on how provider organizations are compensated and even structured. The 2 percent across-the-board cuts to Medicare from the federal budget sequestration represent the most recent example of downward price pressure.

Another potential future shift is that consumer and physician sentiment increasingly is in favor of a single-payer system. A 2008 poll published in the *Annals of Internal Medicine* showed that 59 percent of physicians supported a single-payer model. That figure was up from 50 percent in 2002. Shortly after we met in February, a cover story in *Time* magazine argued that one guaranteed way to bend the healthcare cost curve would be to lower the age of Medicare entry, not raise it. If the cost problem isn't solved, the implications for the industry could include revolutionary measures that would be forced on the system.

Several attendees considered radical changes that could modify the system. Some suggested eliminating primary care as we know it. The concept isn't as foreign as it may seem, and underlies a belief that much of the care provided in a doctor's office can be handled elsewhere by nurses, pharmacists, behavioral specialists and other experts. Others suggested that an overnight shift to physician pay based on measured quality outcomes, cost efficiency and patient experience would rapidly lead to a transformed system.

Consumer Empowerment—Provider and Vendor Market Leaders Pave the Way

- **Phil Fasano**, Executive Vice President and Chief Information Officer, Kaiser Permanente
- **Kelly Clark**, Chief Information Officer, OptumHealth

While many in the healthcare community talk about the system being completely overhauled within a decade, others suggest that because consumers are quickly being empowered, educated and enabled, the timeline will be shortened dramatically. Also fueling this transformation are consumer-centric private equity investments, which are funneling millions into healthcare businesses. Solutions include being able to inexpensively diagnose cancer by breathing on a microchip or using $100 smartphone-enabled electrocardiograms that will eliminate the need for in-hospital equipment plus the technicians and overhead associated with exam rooms. According to the firm CB Insights, $28 billion was invested in healthcare startups in 2012, and the trend indicates those numbers will rise in the coming years. This new technology-enabled world promises to create healthcare that operates in real time, every day of the year—but only when consumers need it and want it.

Many believe the end result of this investment is that if traditional providers don't deliver cost-effective solutions to consumers, then other non-traditional companies will step into the breach. Competitors of the future likely may be organizations such as Apple, GE Health, IBM and Oracle. Not only are these companies used to fast-paced innovation and agile business processes, they all share the advantage of not being caught in the middle of legal reform that is transforming their business model.

On the provider side, figuring out the economic models in a pay-for-quality environment won't be simple. Physicians traditionally don't like to be surveyed on the quality of their care; but they are interested in increasing their revenue, and reconciling those issues will be challenging. As we noted at the beginning of this paper, almost half of all physicians believe quality measures would have a negative impact on the care they deliver. Several ventures aim to evaluate doctors, thus seemingly empowering consumers. However, there's a counter-movement of physicians using companies such as Medical Justice Services to manage and curtail poor online reviews, often by way of doctor-patient confidentiality contracts. While a number of physicians are seeking to control information, the social trend of sharing information online, even about healthcare, is expanding—a direction that many in our group felt should be encouraged.

The Cost Management Imperative—Retooling Health Product Business Plans and Market Access Strategies

- **Joseph Smith, Ph.D.**, M.D. and Fellow of the American College of Cardiology, Chief Medical Officer and Chief Science Officer, West Health
- **John Driscoll**, President, Castlight Health
- **Steve Newman, M.D.**, former Tenet Chief Operating Officer, Board Member at Optimer Pharmaceuticals, Inc. and Hansen Medical, Inc.
- **Chip Davis, Jr., J.D.**, Executive Vice President of Advocacy, Pharmaceutical Research and Manufacturers of America

During these Roundtable discussions, there was a consistent back and forth around technology. Many viewed it as an industry-transforming tool, others cautioned that it's simply a catalyst. Patients who represent the largest share of costs in the system are the least likely to use technology to engage with the healthcare system. For example, it's estimated that 75 percent of healthcare dollars are spent treating the chronically ill and the elderly. Similarly, 96 percent of Medicare dollars are spent on the management of chronic diseases. Alzheimer's also threatens to hobble the system. One estimate heard at the Roundtable suggested that if there's no major breakthrough in the treatment for Alzheimer's by 2050, there will be 13 million additional Americans afflicted with this condition. The cost for caring for this group will be on the order of $1 trillion a year.

It's worth underscoring that these patients, who represent an enormous percentage of healthcare expenditures, are not the ones who will be adopting the latest technologies. While many noted that private equity and venture capital flooding into healthcare is a sign of an expanding competitive field, others pointed out that $30 billion isn't enough to transform an industry that, historically, is very conservative.

However, there are unmistakable bright spots. New programs that allow employees to make decisions about the cost and quality of their care are entering the market. With high deductibles now part of an increasing share of employee health plans, consumers have an incentive to save money. In one case, 70 percent of employees signed up for a cost and quality monitoring program, and 40 percent of them continued to use the program even after they had reached their deductible. This indicates consumers continued to search for care based on value even when they no longer had a financial incentive to do so. The trend in which consumers are more involved with their healthcare comes at a time when attorneys general and state legislatures around the country are joining the call for cost and quality transparency. Consumers, among others, now believe they have a right to this type of information and healthcare data, and many attendees believe this assumption will change the industry.

Authors

Carol Emmott leads the firm's Health Services Practice and specializes in executive officer and board of directors assignments for academic, nonprofit and for-profit hospitals and health systems, multi-specialty medical groups and other vendors and providers of advisory services to the health services industry. Based in San Francisco, she has also recruited senior leaders across a wide array of for-profit and nonprofit managed care companies.

Barbara Anderman is a member of Russell Reynolds Associates' Health Services, Technology, CIO and Digital Transformation Practices. Based in San Francisco, Barbara brings her clients an in-depth knowledge of healthcare operations, working within both for-profit and non-profit sectors.

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Americas

Atlanta
1180 Peachtree St., NE
Suite 2250
Atlanta, GA 30309-3521
United States of America
Tel: +1-404-577-3000

Boston
One Federal Street, 25th Floor
Boston, MA 02110-1007
United States of America
Tel: +1-617-523-1111

Buenos Aires
Buenos Aires Plaza
Manuela Sáenz 323
Seventh Floor, Suites 14 and 15
C1107BPA, Buenos Aires
Argentina
Tel: +54-11-4118-8900

Calgary
Suite 750, Ernst & Young Tower
440-2nd Avenue SW
Calgary, Alberta T2P 5E9
Canada
Tel: +1-403-776-4192

Chicago
155 North Wacker Drive
Suite 4100
Chicago, IL 60606-1732
United States of America
Tel: +1-312-993-9696

Dallas
200 Crescent Court, Suite 1000
Dallas, TX 75201-1834
United States of America
Tel: +1-214-220-2033

Houston
600 Travis Street, Suite 2200
Houston, TX 77002-2910
United States of America
Tel: +1-713-754-5995

Los Angeles
11100 Santa Monica Blvd.
Suite 350
Los Angeles, CA 90025-3384
United States of America
Tel: +1-310-775-8940

Mexico City
Torre Reforma
Paseo de la Reforma
115-1502
Lomas de Chapultepec
11000 México, D.F.
México
Tel: +52-55-5249-5130

Minneapolis/St. Paul
225 South Sixth Street, Suite 2550
Minneapolis, MN 55402-3900
United States of America
Tel: +1-612-332-6966

New York
200 Park Avenue
Suite 2300
New York, NY 10166-0002
United States of America
Tel: +1-212-351-2000

Palo Alto
260 Homer Avenue, Suite 202
Palo Alto, CA 94301-2777
United States of America
Tel: +1-650-233-2400

San Francisco
101 California Street
Suite 2900
San Francisco, CA 94111-5829
United States of America
Tel: +1-415-352-3300

São Paulo
Edifício Eldorado Business Tower
Av. Nações Unidas, 8.501 11°
05425-070 São Paulo
Brazil
Tel: +55-11-3566-2400

Stamford
301 Tresser Boulevard
Suite 1210
Stamford, CT 06901-3250
United States of America
Tel: +1-203-905-3341

Toronto
Scotia Plaza, Suite 3410
40 King Street West
Toronto, ON
M5H 3Y2
Canada
Tel: +1-416-364-3355

Washington, D.C.
1701 Pennsylvania Avenue, NW
Suite 400
Washington, DC 20006-5810
United States of America
Tel: +1-202-654-7800

Asia/Pacific

Beijing
Unit 3422 China World Tower 1
No. 1 Jian Guo Men Wai Avenue
Beijing 100004
China
Tel: +86-10-6535-1188

Hong Kong
Room 1801, Alexandra House
18 Chater Road Central
Hong Kong
China
Tel: +852-2523-9123

Melbourne
Level 51, Rialto Towers
525 Collins Street
Melbourne, VIC 3000
Australia
Tel: +61-3-9603-1300

Mumbai
Unit 9(A), Grand Hyatt Plaza
Santacruz (East)
Mumbai 400 055
India
Tel: +91-22-6733-2222

New Delhi
203, Eros Corporate Tower
Nehru Place
New Delhi 110 019
India
Tel: +91-11-4603-4600

Seoul
16F West Tower
Mirae Asset Centre 1 Building
26 Eulji-ro 5-gil, Jung-gu
Seoul 100-210
Korea
Tel: +82-2-6030-3200

Shanghai
Room 4504, Jin Mao Tower
88 Century Avenue
Pudong, Shanghai 200121
China
Tel: +86-21-6163-0888

Singapore
2 Shenton Way
#08-01 SGX Centre 1
Singapore 068804
Singapore
Tel: +65-6225-1811

Sydney
Level 40 Aurora Place
88 Phillip Street
Sydney NSW 2000
Australia
Tel: +61-2-9258-3100

Tokyo
Izumi Garden Tower 14F
1-6-1 Roppongi
Minato-ku, Tokyo 106-6014
Japan
Tel: +81-3-5114-3700

Europe

Amsterdam
World Trade Center
Tower H, 18th Floor
Zuidplein 148
1077 XV Amsterdam
The Netherlands
Tel: +31-20-305-7630

Barcelona
Edificio Prisma
Avda. Diagonal, 613, 2°A
08028 Barcelona
Spain
Tel: +34-93-494-9400

Brussels
Boulevard St. Michel 27
B-1040 Brussels
Belgium
Tel: +32-2-743-12-20

Copenhagen
Kongens Nytorv 3
DK-1050 Copenhagen K
Denmark
Tel: +45-33-69-23-20

Frankfurt
OpernTurm
60306 Frankfurt am Main
Germany
Tel: +49-69-75-60-90-0

Hamburg
Stadthausbrücke
1-3/Fleethof
20355 Hamburg
Germany
Tel: +49-40-48-06-61-0

London
Almack House
28 King Street
London SW1Y 6QW
United Kingdom
Tel: +44-20-7839-7788

Madrid
Calle Miguel Angel, 11, 7°
28010 Madrid
Spain
Tel: +34-91-319-7100

Milan
Via Mascheroni, 5
20123 Milan
Italy
Tel: +39-02-430-015-1

Munich
Maximilianstraße 12-14
80539 München
Germany
Tel: +49-89-24-89-81-3

Paris
7, Place Vendôme
75001 Paris
France
Tel: +33-1-49-26-13-00

Stockholm
Hamngatan 27
SE-111 47 Stockholm
Sweden
Tel: +46-8-545-074-40

Warsaw
Belvedere Plaza
ul. Belwederska 23
00-761 Warsaw
Poland
Tel: +48-22-851-68-38

Zürich
Löwenstrasse 28
CH-8001 Zurich
Switzerland
Tel: +41-44-447-30-30